TRANSACTIONS OF THE NEW YORK SURGICAL SOCIETY.

Stated Meeting, October 8, 1902.

The President, LUCIUS W. HOTCHKISS, M.D., in the Chair.

GASTROJEJUNOSTOMY FOR CARCINOMA OF PYLORUS.

DR. F. TILDEN BROWN presented a man, aged thirty-four years, who was admitted to the Presbyterian Hospital on July 9 of the present year. His father and one paternal uncle died of cancer of the stomach; his sister and one paternal aunt died of cancer of the uterus.

The patient gave no alcoholic history, but he was always a hasty and irregular eater. Fifteen years ago he suffered from insolation, with delirium for two months. He made a complete recovery, and has always been strong and well with the exception of occasional attacks of indigestion. About a year ago he began to have a burning pain in the epigastrium two or three hours after eating. This pain was relieved by vomiting, which was artificially produced. He was also troubled with flatulence, and for one month after the onset of his illness he suffered from severe diarrhœa. These symptoms have persisted, with varying intensity, up to the present time. His appetite is very poor, and he has lost about twenty pounds in weight during the past year. The epigastric pain is not constant; there is no tenderness nor jaundice. For the past three or four months his feet and legs have become swollen on standing, and at times his face and eyelids are puffy in the morning. There is slight dyspnœa and cough.

From July 9 until the 24th the patient was kept under observation on the medical side of the hospital. A physical examination was practically normal. The stomach, when dilated with water, percussed to two inches below the umbilicus. Lavage gave no

relief to the symptoms. An examination of the blood shows red blood-corpuscles, 4,660,000; hæmoglobin, 75 per cent.; leucocytes, 7650. An analysis of the stomach contents was acid to litmus, and gave a free hydrochloric acid reaction of .0438 per cent.; total acidity, .233 per cent.; no lactic acid, no butyric acid. The liver percussion extended from the fifth to the ninth intercostal space; its free edge could not be felt. The abdomen was very much retracted, with moderately lax walls. No tenderness could be elicited on pressure and no masses could be felt.

A diagnosis of pyloric obstruction was made, probably benign in character. On July 24 a five-inch median incision was made between the umbilicus and the ensiform cartilage. The stomach was found to be greatly dilated. Surrounding the pyloric extremity and extending along the lesser curvature of the stomach was an irregular, hard mass, about the size of an average adult fist, and evidently carcinomatous. Numerous enlarged lymph glands were felt in different directions. The anticipated pyloroplasty for stenosis was supplanted by a gastrojejunostomy. Parts of the omentum, transverse colon, and greater curvature of the stomach were wrapped in hot towels at the upper end of the wound; the jejunum, identified by Treitz's ligament, was then drawn out and its proximal and distal parts marked by a white and black silk suture; the transverse mesocolon was pierced and the posterior wall of the stomach drawn through. The adjacent serous surfaces of the stomach and jejunum were then united by silk Lembert sutures; one-quarter of an inch in front of this line a two-inch one-half incision was made in each viscus; these were treated with interrupted silk sutures, and the anterior surfaces of the apertures managed in the same way.

The patient rallied well after the operation. He was fed at the beginning of the third day without causing nausea or vomiting, and began to pick up rapidly in weight; so much so that his gain was very striking day by day. He left the hospital on August 21, and his weight has increased from 95 to 145 pounds. There is now a mass in the epigastrium which is easily palpable.

GASTROSTOMY.

DR. W. G. LE BOUTILLIER presented a man, forty-eight years old, who, five months previous to his admission to hospital, had swallowed a fish-bone, which caused some pain in his neck and

the expectoration of a little blood. Six weeks later he began to have some difficulty in swallowing solid food; this dysphagia rapidly increased, and when he came to the hospital the obstruction of the œsophagus was almost complete. No instrument could be passed beyond an obstruction located seven and one-half inches below the line of the teeth, and fluids could be swallowed only very slowly. A few days before his admission to the hospital he had developed a laryngitis, which still persists. This gave rise to the suspicion of aneurism, but an examination of the throat showed a simple laryngitis.

A gastrostomy was done by Dr. Le Boutillier, following the Kader method, on August 25, 1902, and the man has since been fed through the stomach. He has gained about fifteen pounds in weight. There is practically no leakage from the artificial opening, and hence no irritation of the skin.

Two years ago, the speaker said, this same patient was operated on by him for an inguinal hernia by the Bassini method. He resumed his occupation as a nurse some four weeks after the operation, has worn no truss or external support, and there are no indications of a recurrence.

RESECTION OF FIVE FEET OF SMALL INTESTINE FOR MALIGNANT DISEASE.

DR. B. FARQUHAR CURTIS presented a man thirty-three years of age. He had been ailing for some months before he came under Dr. Curtis's observation. At that time he already showed signs of emaciation, and was suffering from intense pain, which spread over the entire abdomen, but seemed to be most severe in the neighborhood of the appendix. He had an easily palpable mass in that situation, and another, which was less distinct, up towards the umbilicus. There were no stomach symptoms, no constipation, no history of passing pus or blood per rectum. While the diagnosis was uncertain, it seemed probable that the case was one of malignant growth involving the intestine.

The man was operated on by Dr. Curtis at the General Memorial Hospital on May 13 last. He made a split-muscle incision in the region of the appendix, and found a mass of large size, which was evidently connected with the small intestines. It was freely movable, and, in order to explore it thoroughly, a

median incision was made higher up. He then found that six inches of what seemed to be the jejunum were involved in this growth, which measured over three inches in diameter. All the coats of the bowel were invaded. The bowel was enlarged in its external diameter, the walls much thickened; but the lumen was reduced very slightly, ulceration internally having kept pace with the growth of the tumor. In the adjoining mesentery were a few enlarged glands, and also towards the root of the mesentery. After isolating the mass and enucleating the involved glands in the mesentery, it was seen that the blood-supply of six feet of the small intestine had been cut off. This portion of the gut was therefore removed, and the divided ends united with a Murphy button, which the patient passed on the sixth day. He was discharged from the hospital about a month after the operation, and during the two subsequent months his condition was very good. He gained in weight, and his bowels moved twice daily, the passages being normal, in spite of the large segment of gut removed. Since August he is again beginning to lose ground. He is now somewhat anæmic, and has lost his appetite. The former pain has not returned, but he suffers somewhat from pain in the back.

The length of intestine removed measured, while in a fresh state and still attached to the mesentery, a little over sixty inches. The pathologist reported that it measured seventy-two inches, but this was after its separation from the mesentery. This places the case among those of extensive removal of the intestine, and the good condition of the patient is of interest in that connection. The pathologists reported that the growth was a carcinoma.

Dr. Curtis said that at the time of operating on this patient he noticed a small nodule on the neck, behind the clavicle. Since then this mass has continued to grow, and it is now of considerable size. While this tumor in the neck may be a mere coincidence, the speaker said he was inclined to believe it was connected with the thoracic duct. On account of its situation, he did not think it wise to attempt its removal by surgical intervention. The X-rays are being applied to it, as well as to the abdomen, where there are some vague signs of recurrence.

Dr. Lilienthal said he did not think there was anything surprising in the fact that Dr. Curtis's patient had only two daily movements of the bowels, and that they were normal in character,

in spite of the loss of such a large segment of the small intestine. The speaker referred to a case which he presented about eighteen months ago in which a few inches of the ileum and the entire colon —ascending, transverse, and descending—were removed, and in spite of this the patient had only two movements of the bowels daily. Immediately after the operation she suffered for a time from frequent, loose passages, but they finally became solid and the number decreased to two daily. This has continued up to the present time, and when he last heard from the patient, a few days ago, she was apparently enjoying excellent health. Dr. Lilienthal said that if this is so after removal of the entire colon, one would not expect diarrhœa after the loss of even five feet of small intestine.

INTRACRANIAL NEURECTOMY FOR TIC DOULOUREUX.

Dr. Robert Abbe read a paper with the above title, for which see the Annals of Surgery for January, 1903.

Dr. John F. Erdmann said that in the latter part of September he operated upon a woman who had long suffered from tic douloureux. He had proposed for over a year the removal of the Gasserian ganglion, but the patient refused to submit to it, on the ground that it would necessitate the loss of her hair; and he thereupon resorted to the operation of Jonnesco in July of this year, which was suggested by an Italian surgeon, G. Carazzani, for the relief of these cases, namely, removal of the superior sympathetic ganglion. This operation did not give her immediate relief, but her attacks of pain gradually became less frequent and less intense. This improvement was only temporary, however, and at the end of a month her former attacks returned with increased severity, so that two weeks ago she consented to removal of the Gasserian ganglion, and this was done.

Dr. Erdmann said that in two other cases where he had operated, he removed the second and third branches of the nerve and the ganglion of Gasser according to the classical description by Hartley. As to the possibility of injuring the brain substance by too strong retraction of the parts, he said that in his last case the retractor was turned over to an assistant, who probably exercised a little too much force, and, as a result of the pressure upon

the brain, the patient remained totally unconscious for nine days subsequent to the operation. She is now completely recovered and absolutely relieved.

DR. CURTIS referred to the possibility of obstinate hæmorrhage as a complication in this operation. About a year ago last June he operated on a young man; and when he had partially completed the bone-flap, the bleeding, which had been quite profuse from the beginning, became so severe and uncontrollable that he packed the wound and temporarily abandoned the operation. Two or three days later he reopened the wound, but was again obliged to desist on account of the profuse hæmorrhage. A few days later, during Dr. Curtis's absence from the city, Dr. Stewart again reopened the wound and met with the same condition of affairs. The hæmorrhage was still so severe that nothing could be done, and he thereupon closed the wound permanently. During the patient's subsequent stay in the hospital he had no attacks of pain, having apparently been benefited by the incomplete operation. The man was not a "bleeder"; at least, there was no previous history of it, and the blood formed clots well.

DR. WILLY MEYER said he had done the operation of removal of the Gasserian ganglion a few times. In his first case he used the chisel, but he now employs the Gigli saw for the purpose of cutting through the bones, and by this method much valuable time is saved. In one instance he accidentally tore the meningeal artery when just ready to tie it, resulting in a very annoying hæmorrhage; but it was comparatively easy to check this by compressing the artery in the foramen and then resort to torsion. In none of his cases, Dr. Meyer said, was he obliged to desist on account of the bleeding, although he could readily imagine such an instance. Krause has stated that when the hæmorrhage is very severe, he would resort to pressure for a period of even half an hour, if necessary, in order to complete the operation in one sitting, for aseptic reasons.

Dr. Abbe has apparently demonstrated by his cases that the Gasserian ganglion need not be entirely removed, although in the literature on this subject the importance of such removal is emphasized. The intervention of the rubber tissue seems to prevent a reunion of the central and peripheric portion of the nerve.

Dr. Meyer said that in one of his earlier cases his assistant

pulled too strongly on the retracting hook. This, apparently, produced no immediate injurious effect, as the patient made a perfect recovery. A number of weeks later, however, he suddenly developed a high temperature without any assignable cause. It was first thought to be due to malaria, but he died suddenly, and an autopsy disclosed an abscess of the temporal lobe. This was probably the result of direct injury to the brain due to pressure, although the fact should be mentioned that catgut was used in closing the wound, and two small stitch abscesses had developed. Dr. Meyer said he now uses silkworm gut for suturing the skin in these cases, never catgut.

DR. ABBE, in closing, said he looked upon rubber tissue as a valuable adjunct to surgical work. Among other things, he uses it in the treatment of ulcers, which rapidly cicatrize under a cover of rubber tissue. In the cases described in his paper, the rubber tissue covering the foramen apparently holds the nerve-cell proliferation in check until the proliferating process in the nerve stumps ceases.

In regard to the possibility of injuring the brain tissue by pressure, Dr. Abbe said that in order to avoid this he now holds the retractor himself, at the same time doing the dissection, and in this way he exerts just enough traction to give him the necessary room. The brain is elevated very gently, and with a small, blunt steel dissector the necessary work is done about the roots of the nerve.

In reply to a question, Dr. Abbe said he never intentionally opened the dura in operating on these cases.